

Nursing Services

Definition: Nursing services are continuous or intermittent care provided by a nurse, licensed in accordance with the State's Nurse Practice Act, in accordance with the recipients' plan as deemed medically necessary by a physician.

Providers: Nursing services are provided by agencies or companies enrolled with SCDHHS to provide Nursing Services.

Arranging for the Services: Only a physician can determine if nursing services are needed and if needed, the amount needed and skill level required. The need for the service must be documented by the **Physician's Order for Nursing Services (MR/RD Form 28)** and in the recipient's plan. The skill level required (RN or LPN) must be noted and followed. A RN can provide care if the order is written for a LPN; however, the provider can only claim the LPN rate for that consumer when billing SCDHHS. A LPN **cannot** provide services when a RN is ordered by the physician.

If a child (under 21 years old) is receiving ventilator care, tracheostomy care, endotracheal care, enteral feedings or parental feedings, the attached checklist in this chapter, "Checklist for Children with Medically Complex Conditions requiring Private Duty Nursing" (MR/RD Waiver Form A-12A) is to be used for documentation of the services. The Service Coordinator will complete this checklist based on information from the person's health care providers or medical information in the person's record.

A child with a medically complex condition is a child with complex medical needs who has one or more of the following: 1. a diagnosable, enduring, life-threatening condition, 2. a medical condition that has resulted in substantial physical impairments, 3. medically caused impediments to the performance of daily, age-appropriate activities at home, school or community).

Please note the following definitions for items referenced above and in the checklist (MR/RD Waiver Form A-12A) to make a determination of a medically complex condition if it is not noted specifically in any medical documentation in the record:

□ **External nutrition via NG tube, G-tube, or J-tube:**

External Nutrition is the provision of nutrients through the gastro-intestinal tract when the consumer cannot ingest, chew, or swallow food, but can digest and absorb nutrients.

- NG tube – a tube passed through the nose into the stomach
- G-tube –(gastrostomy) a tube that has been surgically inserted into the stomach through the abdominal wall
- J-tube – jejunostomy feeding) a surgical procedure to create an artificial opening to the jejunum (a portion of the small intestine) through the abdominal wall

□ **Tracheostomy Care:**

(tracheostomy – an opening through the neck into the trachea through which an indwelling tube may be inserted)

Tracheostomy care is provided to the tracheostomy which consists of maintenance of a patent airway, adequate humidification, aseptic wound care, and sterile tracheal aspiration.

□ **Nasopharyngeal or tracheostomy suctioning:**

Suctioning clears mucus from the [tracheostomy](#) tube and is essential for proper breathing. This clean/sterile procedure requires specialized equipment; i.e., suction machine, saline water, gloves, catheter, etc. Must be familiar with the procedure prior to implementation.

□ **Parenteral Nutrition:**

Parenteral Nutrition is the administration of nutrients by a route other than through the digestive /alimentary canal (not within the intestines), such as subcutaneously (under the skin), intravenously (inside the vein), intramuscularly (pertaining to the interior of muscle tissue), or intradermally (within the tissue of the skin).

Parenteral: Situated or occurring outside of the intestines.

- **TPN or Hyeralimentation.** TPN (total parenteral nutrition) - the administering of nutritionally adequate hypertonic solution through an indwelling catheter into the superior vena cava (second largest vein of the body located on the right side of the chest).

□ **Endotracheal:**

(within or through the trachea); a flexible plastic tube that is put in the mouth and then down into the trachea (airway).

Once it is determined that services are needed, the recipient/legal guardian should be provided with a list of enrolled Medicaid Nursing Services Providers and asked to select a company to provide the service. The Service Coordinator/Early Interventionist should assist as needed by the recipient/legal guardian. This offering of choice must be documented in the recipient's file.

For nursing services, one unit equals one hour of service. The rate paid for each unit depends upon the skill level required (i.e., RN is more expensive than LPN). Once the amount needed is determined, the needed units must be entered into the Waiver Tracking System (S68-LPN or S69-RN; S47-LPN Specialized Child (Enhanced Nursing) or S07-RN Specialized Child (Enhanced Nursing)) and approval obtained before services can be authorized. **Please note, the maximum number of nursing units that can be funded by the Waiver is 60 hours per week when the services are provided by an LPN or 44 hours per week when services are provided by an RN. If a consumer's needs exceed these identified limits and there is no other funding source to provide the additional nursing (e.g. private insurance), please contact the appropriate MR/RD Waiver Coordinator for directions on how to proceed.**

For those recipients that have private insurance, Nursing Service Providers must bill the recipient's private insurance carrier prior to billing SCDHHS/Medicaid for all nursing services provided. MR/RD Waiver Nursing Services should not be billed to SCDHHS/Medicaid until all other resources, including private insurance coverage, have been exhausted. The Service Coordinator/Early Interventionist must first determine if the MR/RD Waiver recipient has private insurance and if the insurance policy covers nursing services. In no instance will SCDHHS pay any amount that is the responsibility of a third party resource. The MR/RD Waiver is the payer of last resort and maximum allowable limits as defined above apply.

The following procedures are to be followed when authorizing Nursing Services:

- When private insurance **covers all** nursing services:
 1. When the private insurance carrier pays for all nursing services deemed medically necessary by a physician, the Service Coordinator/Early Interventionist will indicate the hours of nursing service and private insurance carrier as the payment source in the recipient's plan and no authorization for service is necessary.
 2. In no instance may the recipient be billed any cost sharing amount such as co-payments, deductibles and/or co-insurance.
- When private insurance **covers a portion** of nursing services:
 1. When the private insurance carrier pays for only a portion of the nursing service hours deemed medically necessary by a physician, the Service Coordinator/Early Interventionist will indicate the hours of Nursing Service the private insurance carrier will provide in the recipient's plan and indicate the private insurance as the payment source.
 2. For those additional hours not covered by the private insurance carrier, but deemed medically necessary, the Service Coordinator/Early Interventionist will issue an **Authorization for Service (MR/RD Form A-12)** for those hours not covered by private insurance and indicate the hours in the recipient's plan as funded by the MR/RD Waiver. Providers of Nursing Services must only bill SCDHHS/Medicaid for those hours of Nursing Services not covered by private insurance. If a child is receiving at least one of the services on the checklist (MR/RD Waiver Form A-12A), you will need to authorize "Enhanced Nursing Service RN" or Enhanced Nursing Service LPN" as appropriate to cover hours not covered by private insurance.
- When private insurance **covers none** of the nursing services or the recipient does not have private insurance:
 1. When private insurance does not cover any Nursing Services deemed medically necessary by a physician or the recipient's does not have private insurance, the Service Coordinator/Early Interventionist will indicate the hours of Nursing Service in the recipient's plan as being funded by the MR/RD Waiver and complete the **Authorization for Services (MR/RD Form A-12)** for the hours needed not to exceed the applicable limits. If a child is receiving at least one of the services on the checklist (MR/RD Waiver Form A-12A) , you will need to authorize "Enhanced Nursing Service RN" or Enhanced Nursing Service LPN" as appropriate on the authorization form.

Nursing Rates:

| Program | Procedure Description | Reimbursement Rate |
|----------------------|------------------------------|---|
| MR/ RD Waiver | RN nursing | \$33.00 per hour 1 hour = 1 unit |
| | LPN nursing | \$25.00 per hour 1 hour = 1 unit |
| | RN enhanced nursing | \$36.00 per hour (\$9.00/15 min) 1 unit = 15 min. |
| | LPN enhanced nursing | \$28.00 (\$7.00/15 min) 1 unit = 15 min |

When sending the **Authorization for Services (MR/RD Form A-12)** to the selected Nursing Provider copy, the Service Coordinator/Early Interventionist must include a copy of the Physician's Order for services and, if applicable, a copy of the checklist for children with medically complex conditions (**MR/RD Form A-12A**).

Upon receipt of the authorization, the company will begin providing services. After the first visit, the Nursing Service Provider will send to you their specific plan for providing nursing services and may suggest changes to the schedule that will affect the units authorized on **Authorization for Services (MR/RD Form A-12)**. If you agree with the suggested changes, the recipient's plan must be updated, the new information entered on the Waiver Tracking System and approved and a new authorization sent to the company reflecting the new units total and start date.

The company must notify you within two (2) working days of any significant changes in the recipient's condition or status. You must respond to requests from the company to modify the recipient's plan within three (3) days of receipt.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient's/family's satisfaction with the service.

Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following criteria should be followed when monitoring Nursing Services (RN/LPN).

- Must complete on-site Monitorship during the first month while the service is being provided unless a Supervisor makes an exception. An exception is defined in the following circumstances:
 - the service is **only provided** in the early morning hours (prior to 7:00 a.m.)
 - the service is **only provided** in late evening hours (after 9:00 p.m.)
 - The exception and approval by the Supervisor must be documented. **NO** other exceptions will be allowed.
- At least once during the second month of service
- At least quarterly thereafter
- Start over with each new provider
- Yearly on-site monitorship required.

This service must be monitored during a contact with the individual/family. It can be supplemented with contact with the service provider. In addition, you should review the nursing notes completed during activities with the individual during an on-site visit. Monitorship of the individual's health status should always be completed as a part of nursing monitorship. Some items to consider during monitorship include:

- Has the individual's medical status changed since your last contact? If the individual was receiving nursing for an acute condition, has the physician been consulted about the continuation of nursing services and the skill level required?
- Have there been any changes to the individual's specific nursing plan developed by the provider/Nurse? If so, does the Service Coordinator have a copy of the plan for the individual's record?
- Is the nursing provider providing the nursing services as authorized?
- Are they arriving on time to provide care to the individual? If the nursing provider does not show up to provide care to the individual, who is providing back-up care in the provider's absence?
- Is the individual satisfied with his/her provider of services?
- Does the nurse show him/her courtesy and respect when providing his/her care?
- Does nursing need to continue?
- What is the expected duration of services at the current level?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a **written** notice must be forwarded to the consumer or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

MR/RD WAVIER

Physician's Order for Nursing Services

Patient's Name: _____

Date of Birth: _____

This patient requires the following care/treatment(s) that must be provided by a nurse licensed by the State of South Carolina.

These services are necessary to maintain his/her health and prevent institutionalization. This patient requires _____ hours per _____ of nursing care to be provide by an:

RN ☐ or LPN ☐ (choose one).

Physician's Signature

Date

Physician's Name (Please print or type)

Address

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER**

**AUTHORIZATION FOR SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

TO: _____

RE: _____

Recipient's Name

/

Date of Birth

Address

Medicaid # / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / / /

Nursing Services:

Total Number of Units Per Week to be Provided: _____ (one unit = 60 minutes)

☐ LPN Hours/Week (S9124): _____

☐ RN Hours/Week (S9123): _____

For Children w/ Complex Medical Conditions (Enhanced Nursing) only:

Total Number of Units Per week to be provided: _____ (one unit = 15 minutes)

☐ Enhanced LPN Units/Week (T1003): _____

☐ Enhanced RN Units/Week (T1002): _____

Start Date: _____

Service Coordinator/Early Interventionist: **Name / Address / Phone # (Please Print):**

Signature of Person Authorizing Services

Date

Checklist for Children with Medically Complex Conditions Requiring Private Duty Nursing (Enhanced Nursing Services)

Name: _____ Medicaid #: _____

Skilled Services:

☐ External nutrition via NG tube, G-tube, or J-tube

☐ Tracheostomy Care

☐ Nasopharyngeal or tracheostomy suctioning

☐ Parenteral Nutrition

Parenteral: Situated or occurring outside of the intestines. TPN or Hyeralimentation.

☐ Endotracheal

Tube through nose or mouth to trachea for breathing.

SC/EI Signature (DDSN): _____ Date: _____

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| MEDICAID HOME AND COMMUNITY-BASED WAIVER |
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SCOPE OF SERVICES
FOR
NURSING SERVICES

A. Objective

The objective of the services is to provide skilled medical monitoring, direct care, and intervention to maintain the participant through home support. This service is necessary to avoid institutionalization.

B. Condition of Participation

1. Agencies of Medicaid nursing services must agree to participate in all components of the Care Call monitoring and payment system.

C. Description of Services to be Provided

1. The unit of service is one hour of direct nursing care provided to the participant. The amount of time authorized does not include travel time.
2. The number of units and services provided to each participant will be dependent upon the needs as established, or approved, by CLTC/DDSN.
3. Nursing services will provide skilled medical services as ordered by the physician and will be performed by a registered nurse (RN) or licensed practical nurse (LPN) who will perform their duties in accordance with state law.

Staffing

The provider must maintain individual records for all employees.

1. The RN or LPN must meet the following requirements:
 - a. Supervised by an RN;
 - b. Licensed by the State of South Carolina or by a state that participates in the nursing compact, to practice nursing;
 - c. Have at least one year experience in public health, hospital, or long term care nursing; and,
 - d. Have a minimum of six (6) hours relevant in-service training per calendar year (The annual six-hour requirement will be on a pro-rated basis during the nurse's first year of employment).

e. PPD Tuberculin Test

No more than ninety (90) days prior to employment, all staff having direct participant contact shall have a PPD tuberculin skin test, unless a previously positive reaction can be documented. The two-step procedure is advisable for initial testing in those who are new employees in order to establish a reliable baseline. [If the reaction to the first test is classified as negative, a second test should be given one to three weeks after the first test. If the second test is classified as negative, the person is considered as being uninfected. A positive reaction to a third test (with an increase of more than 10mm) in such a person within the next few years, is likely to represent the occurrence of infection with M. Tuberculosis in the interval. If the reaction to the second of the initial two tests is positive, this probably represents a boosted reaction, and the person should be considered as being infected.]

In lieu of a PPD tuberculin test no more than 90 days prior to employment, a new employee may provide certification of a negative tuberculin skin test within the 12 months preceding the date of employment and certification from a licensed physician or local health department TB staff that s/he is free of the disease.

Employees with reactions of 10mm and over to the pre-employment tuberculin test, those with newly converted skin tests, and those with symptoms suggestive of tuberculosis (e.g., cough, weight loss, night sweats, fever, etc.) regardless of skin test status, shall be given a chest radiograph to determine whether tuberculosis disease is present. If tuberculosis is diagnosed, appropriate treatment must be given, and the person must not be allowed to work until declared non contagious by a licensed physician.

Routine chest radiographs are not required on employees who are asymptomatic with negative tuberculin skin tests.

Employees with negative tuberculin skin tests shall have an annual tuberculin skin test.

New employees who have a history of tuberculosis disease and have had adequate treatment shall be required to have certification by a licensed physician or local health department TB staff (prior to employment and annually) that they are not contagious. Regular employees who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared non contagious.

Preventive treatment should be considered for all infected employees having direct participant contact who are skin test positive but show no symptoms of tuberculosis. Routine annual chest radiographs are not a substitute for preventive treatment. Employees who complete treatment, either for disease or infection, are exempt from further routine radiographic screening, unless they develop symptoms of

tuberculosis. Employees who do not complete adequate preventive therapy should have an annual assessment for symptoms of tuberculosis.

Post exposure skin tests should be provided for tuberculin negative employees within twelve (12) weeks after termination of contact to a documented case of infection.

Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, S.C. 29201, phone (803) 898-0685.

2. In addition, services must also adhere to the following:

- a. The RN supervisor will be accessible via beeper/phone at all times the RN or LPN is on duty; and,
- b. The RN supervisor will decide the frequency of supervisory visits based on his/her professional knowledge of the participant's situation and health status; however, this may be no less frequently than every 90 days for LPNs and 180 days for RNs. In the event the participant is inaccessible during the time the visit would have normally been made, the visit must be completed within five (5) working days of the resumption of Nursing services. These visits will include a re-evaluation of the participant's condition as well as updating of the plan of care.

Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section. An individual participant record must be maintained.

1. CLTC/DDSN will authorize nursing services by designating the amount, frequency, and duration of service for participants in accordance with the participant's Plan of Service. This documentation will be maintained in the participant's file.
2. CLTC/DDSN will review the participant's Plan of Service within two (2) working days of receipt of the provider's request to modify the plan.
3. CLTC/DDSN will notify the provider immediately if a participant becomes medically ineligible for services and will make every effort to verify Medicaid eligibility on a monthly basis. However, the provider should refer to the language in the DHHS Community Long Term Care Services Provider Manual on pages 1-6 regarding the provider's responsibility in checking the participant's Medicaid eligibility.
4. Prior to the initiation of nursing services, the provider will conduct an assessment and develop a plan of care. This must be done by an RN. If services are to be provided by an LPN, the plan of care must be

developed by the RN supervisor. The provider must send the plan of care to CLTC/DDSN which includes treatment plan and goals. If applicable, recommendations to change the service schedule from the initial authorization may be sent to CLTC/DDSN. For CLTC Participants: this visit must be recorded in Care Call.

5. The provider will be responsible for procuring the direct care skilled nursing orders from the physician. The physician's orders must be updated at least every 90 days and maintained in the participant record.
6. Nursing services must begin on the date negotiated by CLTC/DDSN and the nursing services provider. Payment will not be made for nursing services provided prior to the authorized start date.
7. The provider will notify CLTC/DDSN within two (2) working days of the following participant changes:
 - a. Participant's condition has changed and the Plan of Service no longer meets the participant's needs or the participant no longer needs nursing services;
 - b. Participant is institutionalized, dies or moves out of the service area;
 - c. Participant no longer wishes to receive the nursing service; or
 - d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.
8. A summary of services provided must be sent to CLTC/DDSN monthly.

F. Administrative Requirements

1. The provider agency shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the provider agency. The provider agency shall notify DHHS within three working days in the event of a change in the agency administrator, address, or telephone number.
2. The organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff shall be set forth in writing. This shall be readily accessible to all staff and shall include an organizational chart. A copy of this shall be forwarded to DHHS at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the provider agency and to DHHS.
3. The provider agency must have written by-laws or equivalents which are defined as "a set of rules adopted by the provider agency for governing

the agency's operations." Such by-laws, or equivalent, shall be made readily available to staff of the provider agency and shall be provided to DHHS upon request.

4. Administrative and supervisory functions shall not be delegated to another agency or organization.
5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the provider agency. A listing of the members of the governing body shall be made available to DHHS upon request.
6. An annual operating budget, including all anticipated revenues and expenses related to items which would under generally accepted accounting principles be considered revenue and expense items, must be submitted to DHHS prior to the signing of the initial contract with DHHS. The provider agency must maintain an annual operating budget which shall be made available to DHHS upon request.
7. The Provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance to protect all paid and volunteer staff, including board members, from liability and/or injury incurred while acting on behalf of the agency. The Provider agency shall furnish annually, between September 1 – September 30, copies of the insurance policies to SCDHHS.
8. The Provider shall maintain an office open during normal business hours and staffed with qualified personnel. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.
9. The provider must develop and maintain a state approved policy and procedure manual which describes how it will perform its activities in accordance with the terms of the contract.
10. The Provider must have an effective written back-up service provision plan in place to ensure that the participant receives the nursing services as authorized. Whenever the Provider determines that services cannot be provided as authorized, the Case Manager/Service Coordinator must be notified by telephone immediately.

Effective July 1, 2007